CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Sutent®– Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

1. What drug is being prescribed? ☐ Sutent® ☐ Other _____

2. What is the patient's diagnosis?
   - ☐ Renal cell carcinoma (RCC)
   - ☐ Gastrointestinal stromal tumor (GIST)
   - ☐ Pancreatic neuroendocrine tumor (PNET)
   - ☐ Chordoma
   - ☐ Lung neuroendocrine tumor
   - ☐ Angiosarcoma
   - ☐ Solitary fibrous tumor
   - ☐ Hemangiopericytoma
   - ☐ Alveolar soft part sarcoma
   - ☐ Thyroid carcinoma
   - ☐ Other _____

3. What is the ICD code? _____

4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #7.

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

6. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #7 and complete this form in its entirety.

Complete the following section based on the patient's diagnosis.

<u>Section A: Renal Cell Carcimona</u>

7. Is the disease relapsed or medically unresectable? ☐ Yes ☐ No

8. Will Sutent® be used as a single agent? ☐ Yes ☐ No

<u>Section B: Gastrointestinal Stromal Tumor (GIST)</u>

9. Has the disease progressed on Gleevec® (imatinib) therapy? *If Yes, no further questions* ☐ Yes ☐ No

10. Was the patient intolerant to Gleevec® (imatinib)? ☐ Yes ☐ No

<u>Section C: Pancreatic Neuroendocrine Tumor (PNET)</u>

11. Is the disease unresectable, locally advanced, or metastatic? ☐ Yes ☐ No

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Section D: Chordoma

12. Is the disease recurrent? □ Yes □ No

Section E: Thyroid Carcinoma

13. What is the patient's tumor histology? ***If Medullary, indicate below and skip to #16.***
    □ Papillary □ Hürthle cell □ Follicular □ Medullary □ Other _____

14. Is the disease unresectable or metastatic? □ Yes □ No

15. Is the disease progressive or symptomatic? □ Yes □ No

16. Does the patient have tumors at sites other than the central nervous system that were not responsive to radioiodine therapy? □ Yes □ No

17. Is the disease radio-iodine refractory? □ Yes □ No

18. Is Nexavar® an appropriate option for this patient? □ Yes □ No *No further questions*

19. Is the disease progressive or symptomatic? □ Yes □ No

20. Did the disease progress on Caprelsa® (vandetanib) or Cometriq® (cabozantinib)?
    If Yes, no further questions □ Yes □ No

21. Are Caprelsa® (vandetanib) or Cometriq® (cabozantinib) appropriate options for the patient? □ Yes □ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

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